COMMUNITY PARTNERSHIPS EVALUATION

The story so far…….

Iowa Department of Human Services

August, 2008

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INTRODUCTION

BRIEF HISTORY AND CURRENT STATUS

Community Partnerships for Protecting Children (CPPC) is an approach that neighborhoods, towns, cities and states can adopt to improve how children are protected from abuse and/or neglect. The State of Iowa recognizes that the child protection agency, working alone, cannot keep children safe from abuse and neglect. It aims to blend the work and expertise of professionals and community members to bolster supports for vulnerable families and children. Community Partnerships is not a "program" – rather, it is a way of working with families to help services and supports to be more inviting, need-based, accessible and relevant. It incorporates prevention strategies as well as those interventions needed to address abuse, once identified.

In 1997, the Edna McConnell Clark Foundation awarded funding to four communities and states across the nation to implement a community and child welfare reform effort, entitled "Community Partnerships for Protecting Children". The State of Iowa and the community of Cedar Rapids (Linn County) were honored to be one of the four grantees. The Clark Foundation subsequently funded a national organization, the Center for the Study of Social Policy, to provide oversight, technical assistance, and support to each of the four sites and states.

As Cedar Rapids began to implement the initiative, DHS formed a statewide committee to begin identifying lessons being learned from Cedar Rapids' efforts. The first recommendation made by this committee was to hire a statewide coordinator to promote the Community Partnerships approach and to identify ramifications of expanding Community Partnerships to other areas of the state. One national consultant said, "Progress on implementing the initiative beyond Cedar Rapids was not significant until the state hired a fulltime employee to promote and expand Community Partnerships." Additional funding from the Clark Foundation enabled Iowa to roll out the Community Partnerships approach to five Decategorization (Decat) areas within the state in 2001.

The Community Partnerships approach strongly resonated with many Iowa communities. This resonance, coupled with enthusiastic support from the Iowa Department of Human Services (DHS) administration and legislators, resulted in steady and ambitious expansion. It should be noted that legislators from both sides of the aisle have strongly supported this approach. Over the last six years, Iowa has continued to expand the Community Partnerships approach. Today, thirty-nine Decat areas, covering ninety-eight of Iowa's ninety-nine counties, participate in the Community Partnerships approach. Community Partnerships implementation varies across counties and depends on initiation date, pre-existing community assets and local leadership. The Community Partnerships approach has been identified as a significant component of Iowa's improvement plan for the federal child welfare review process (Child and Family Service Review – CFSR).

OUTCOMES AND STRATEGIES

Community Partnerships for Protecting Children (CPPC) is a promising practice approach aimed at preventing child abuse, reducing the number of children experiencing repeated maltreatment, safely decreasing the number of out-of-home placements and promoting timely reunification when children are placed in foster care. The Community Partnerships approach is guided by several key strategies: a) shared decision-making; b) individualized course of action utilizing family team meetings; c) neighborhood/ community networks; and d) policy and practice change. All four strategies must be implemented simultaneously in order to achieve desired results. Through a community shared decision-making process, partners work together to develop policy and practice that promotes individualized planning to meet specific needs of vulnerable families while increasing community networks of both informal and formal supports.

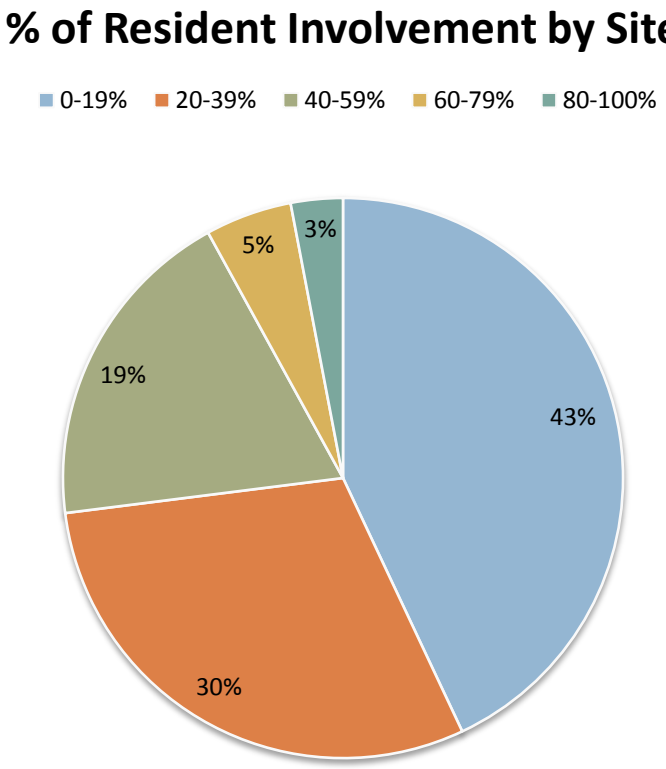
LEVELS OF IMPLEMENTATION

As communities embarked on their CPPC, the level of implementation depends upon a number of factors: 1) length of time as a CPPC community; (2) existing community assets and liabilities; (3) community's ability to collaborate; and (4) leadership strength, stability and ability to motivate others. Recognizing that sites have unique strengths and needs, stakeholders developed an assessment tool (referred to as the "level document") to define and clarify current capacity and ways to assess efforts toward deepening and broadening implementation. Another reason for the tool's development was to provide process measures to identify progress and develop guidance toward meeting desired outcomes. This tool is organized around the four CPPC strategies, with four levels per strategy.

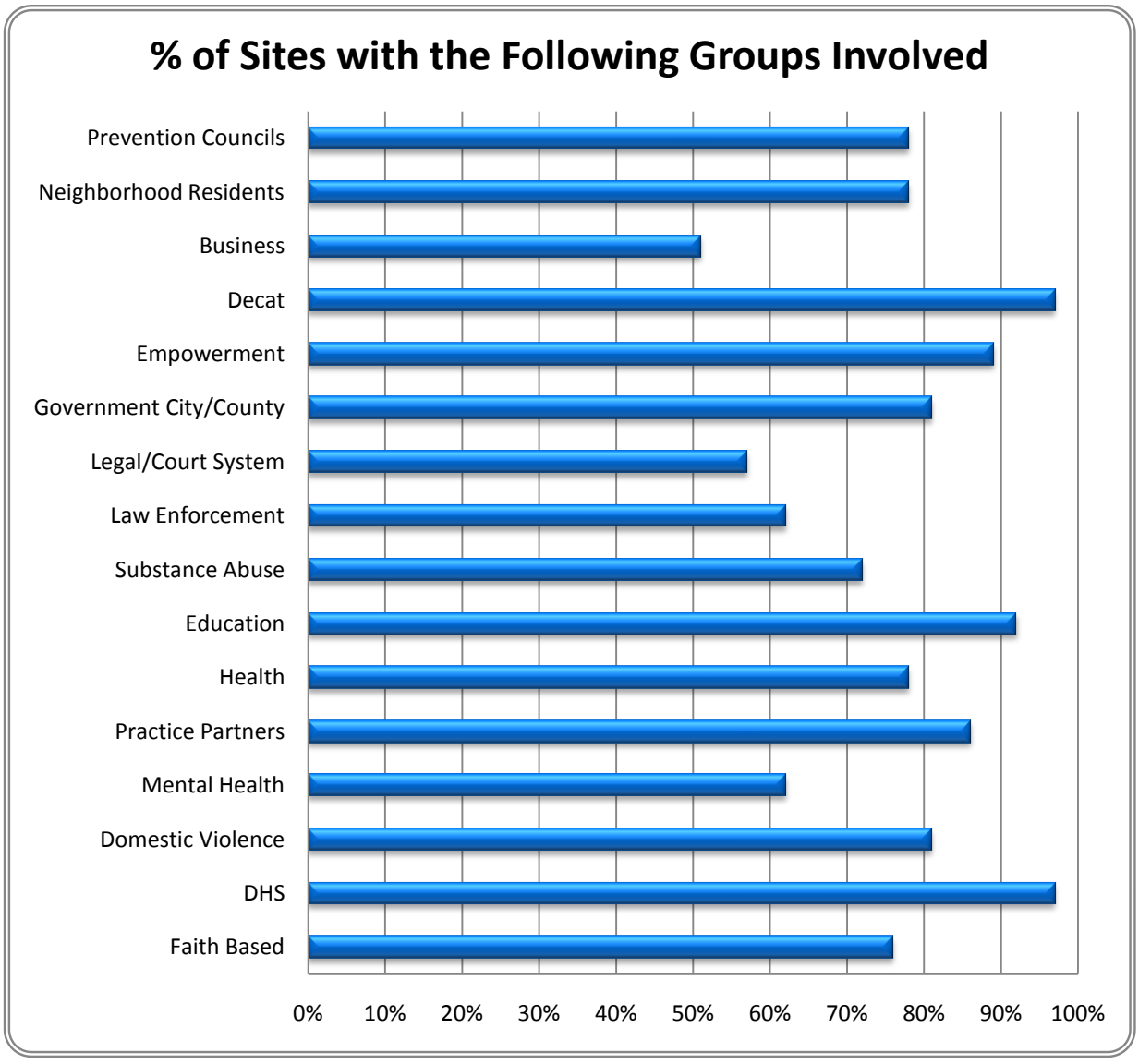
In keeping with the philosophy of shared decision-making, this tool was developed by representatives of CPPC sites based on their actual experiences and capacity. Minimum expectations were defined, with Level 1 representing the early stages. Level 2 builds on the achievements from Level 1. Level 3 is based on Cedar Rapids' implementation because it is most mature CPPC site with the most time invested. Level 4 is based on the vision of ideal Community Partnerships --- one that has not yet been realized, but is still viewed as achievable. A more comprehensive description of the levels is contained within Appendix A.

EVALUATION OF SITE IMPLEMENTATION

Community Partnerships sites are asked to collect performance outcome data on the implementation of all four strategies. All data utilized for analysis in this report was taken from site reports covering the time frame of October, 2006 through September, 2007. One of the most important aspects of CPPC is engaging community residents to be involved in helping to create safety nets in their own communities. The chart below represents the statewide percentage of community residents involved in all four CPPC strategies. Statewide, there are approximately 1,493 professionals and 745 community residents involved in the implementation of the four strategies. The vast majority of this involvement is focused on the neighborhood/community networking strategy. All CPPC sites have residents involved in neighborhood networking and two-thirds of the sites have residents involved in the shared decision-making process.



The chart below represents the percentage of sites that have representation from various community-based programs, organizations and other partners. All but one site have DHS personnel and the Decat coordinator involved in the CPPC. The next highest level of involvement (at least 80%) includes practice partners (agencies and community-based programs), education, empowerment, county or city government and domestic violence agencies. At least 70% of the sites had involvement from the following partners: Child Abuse Prevention Councils; neighborhood residents; substance abuse treatment agencies; health-based programs; and faith-based groups. The four groups with least involvement include law enforcement, the legal system (courts), mental health services and businesses.



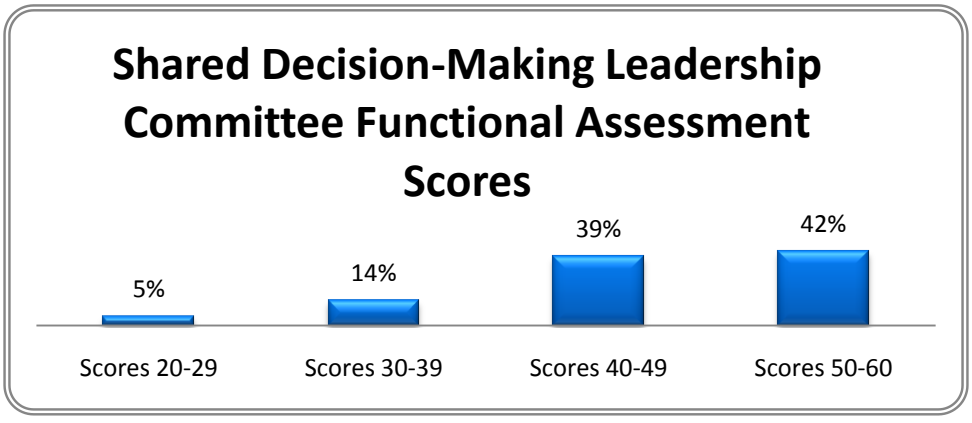
SHARED DECISION-MAKING (SDM)

Community Partnerships sites organize shared decision-making groups at the community level. This local group fosters an understanding of Community Partnerships principles/strategies in order to develop and implement the CPPC plan. Community partners include public and private child welfare agencies, schools, faith-based entities, community members, formerly served DHS parents and youth, domestic violence agencies, substance abuse treatment programs and other providers. This group takes responsibility for setting the ongoing direction of the Partnership and informs the broader public about the purposes and benefits of community child protection. In addition, this group takes primary responsibility for self-evaluation.

Each of the Community Partnerships shared decision-making group assesses the function of its own group by completing a survey. Each member of the group completes a survey, and responses are averaged. The average responses are totaled for an overall score. The highest score possible is 60. A Likert scale was used for the categories listed below with a ranking 1-5, (1=disagree, 2 = mildly disagree, 3 = neutral, 4 = mildly agree, 5 = agree):

- Common Vision
- Understanding and agreement on Goals
- Clear roles and responsibilities
- Shared leadership and decision-making
- Conflict management
- Well developed work plans
- Relations/trust
- Internal and external communication
- Evaluations
- Understanding of CPPC

The majority of the shared decision-making groups viewed the following areas as strengths: having a common vision; relationships built on trust; handling conflict; communication and understanding of CPPC. The Community Partnerships sites that scored highest on the survey are generally mature sites with stable leadership. Surveys show that leadership matters and it can come from surprising sources ---- from DHS administrators to charismatic community organizers and others. The Community Partnerships sites that scored lower tended to be newer or had recent change in leadership roles.

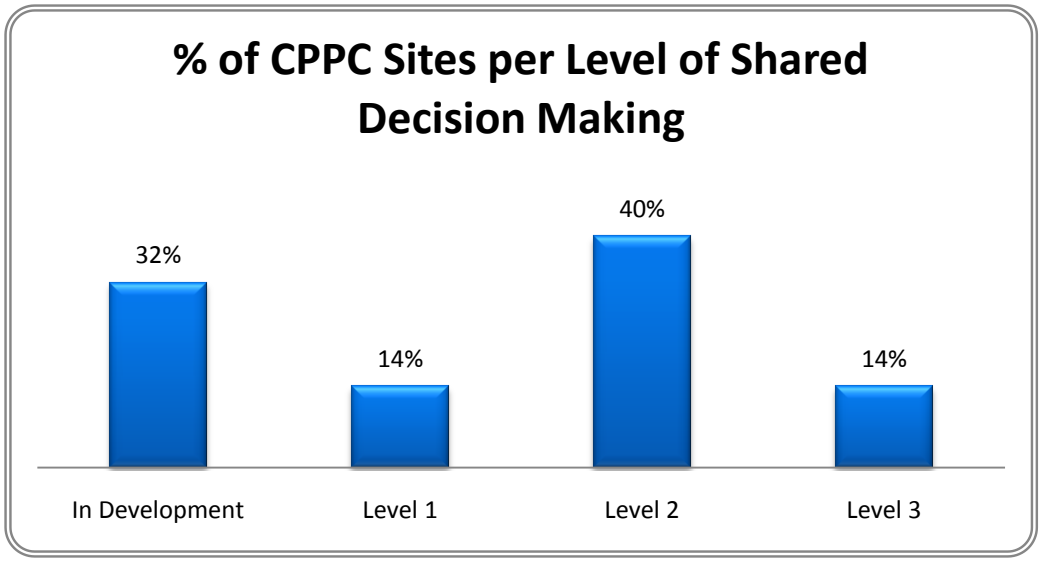


SHARED DECISION-MAKING: LEVELS OF IMPLEMENTATION

The next chart represents the percentages of sites that have implemented shared decision-making according to the four levels of this strategy (see Appendix A for more details on each level). To achieve level 1, sites need to have representatives from DHS, Empowerment/Decat and community and professional members. Several of the newly formed sites do not have community members but have several professional partners. Those sites that have not reached level 1 are identified as "In Development" on the chart.

The trend in the early stages of development seems to be that first the professionals organize and develop strategies for engaging community members. After this initial group fully understands CPPC and implements engagement activities, community members begin to see their roles and start to participate in the shared decision-making process. Community residents often begin their involvement and understanding of CPPC through neighbor/community networking activities. It is anticipated that in the coming years, all shared decision-making groups will have community resident involvement.

The majority of the CPPC sites are at level 2. Sites achieving level 2 have all the representatives identified in level 1 plus four additional partners and one of the following: domestic violence, substance abuse treatment and/or mental health providers. Level 3 includes participation identified in level 1 & 2 plus many more specific representations from a wide range of community-based organizations, agencies and others (i.e. schools, faith-based communities, legal system, etc.).



SHARED DECISION-MAKING: LESSONS LEARNED

- One of the first issues to address is to provide consistent, on-going coordination.
- Passionate leadership is key to implementing the CPPC strategies.
- In the developmental stages, the shared decision-making (SDM) group is primarily professionals. These participants focus on developing a comprehensive understanding of CPPC.
- The SDM committee needs to develop concrete action steps for engaging and educating community members as well as other targeted partners.
- It is important to have active DHS participation on the SDM committee in order to develop a comprehensive plan for addressing needed supports in the community and strengthening Partnerships.

Each SDM group needs to identify an assessment process, review child welfare data and/or quality services review data and/or other sources of evaluation to determine gaps in supports and services. This can provide valuable information and give direction to planning and resource allocation processes. The SDM group needs to use this information to define short-and long-term outcomes. Future development needs to include more technical assistance and training on the assessment process and how to utilize this information to shape the planning process that targets community needs as well as encompasses the four CPPC strategies.

COMMUNITY/NEIGHBORHOOD NETWORKING

Each partnership organizes a network of neighborhood and community groups to support the overall mission of community child protection. Core members of networks include the following: schools, faith institutions, mental health and healthcare providers, substance abuse treatment and domestic violence programs, police, child care providers, parent groups, private child welfare agencies and DHS. In 2007, 292 networking activities were held statewide. These networking activities involved thousands of participants and involved all levels of implementation.

COMMUNITY/NEIGHBORHOOD NETWORKING: LEVELS OF IMPLEMENTATION

Level 1 of Neighborhood/Community Networking focuses on community awareness that engages, educates and promotes community involvement in strengthening families and creating safety nets for children in their own communities. Level 2 focuses on increasing and building linkages between professional and/or informal supports. This level also identifies domestic violence, substance abuse treatment, and mental health professionals as key players in these efforts.

Level 3 involves organizing groups or networks of community residents and/or parents formerly involved in child welfare and/or youth to provide informal supports to vulnerable

families. Neighborhood/Community Networking level 3 includes the following programs and initiatives: Parent Partners, Youth Transitioning Initiative, Circles of Support, Neighborhood Partners and Moms Off Meth. Level 4 includes the implementation of levels 1-3 with at least two or more level 3 programs.

Neighborhood/Community Networking level 3 and 4 programs and initiatives were selected because each incorporates and strengthens the four CPPC strategies. These programs are shaped through a shared decision-making process, provide individualized supports for families and youth, are part of the fabric of neighborhood networks, and influence policy and practice changes. The following program descriptions are examples of level 3 programs that are being promoted and implemented through CPPC efforts.

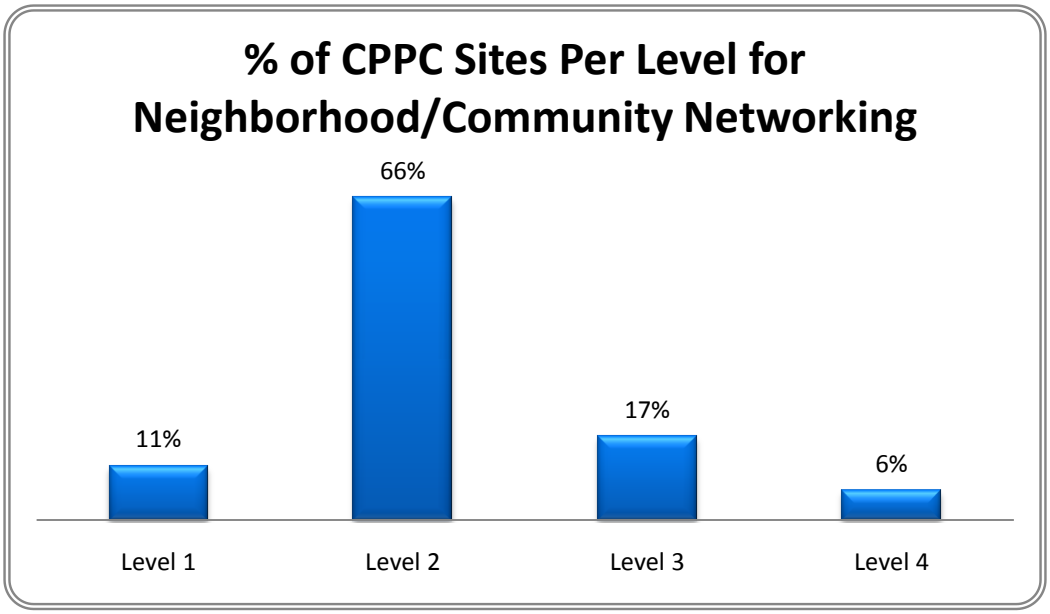
The Parent Partner Program is about parents helping parents who are involved with the child welfare system. Parent Partners are advocates who have been through the system themselves and have successfully reunified with their own children. They have come back to assist DHS in engaging parents who have recently had their children removed. The primary goal is to help these parents safety reunify with their children. Parent Partners provide support and motivation for those parents who need that extra push to begin their case plan activities. At the time data was collected, four Community Partnership sites have implemented the Parent Partner program. During the last year, eight trainings were held and approximately 30 Parent Partners served 65 families.

Transitioning Youth Initiative (TYI) focuses on building collaborative efforts, increasing partnerships, integrating services and resources to improve outcomes among youth over the age of 16. The initiative focuses on youth who are involved in or who have aged out of Iowa's foster care system. The three TYI communities began implementing collaborative efforts focused on the four CPPC strategies: shared decision-making, individual courses of action, neighborhood networking, and policy and practice change. Through these Community Partnership efforts, the ***Iowa Youth Dream Team*** process was developed. This is a youth-centered planning and practice model that empowers youth to take control of their lives and achieve their dreams. Supportive adults and peers create a team to help the youth make connections to resources, education, employment, health care, housing, and supportive personal and community relationships. Through these connections and relationships, young people are better able to access and take advantage of the resources, knowledge, and skills needed to support themselves and realize their dreams.

Circles of Support consists of both participants and allies who volunteer their time, talents, and gifts to build a community where everyone has a network of friends and informal supports. Participants are people who face barriers such as poverty, poor parenting skills or social isolation. Allies are people who support participants in addressing barriers. Participants and allies build relationships (with one another and others) by coming together to share in a meal and evening programming. This gathering helps to build friendships and trust, to share experiences, learn new skills and get involved in community efforts. Both allies and participants complete an interest survey early on that is used to match participants and allies, forming Circles of Support, based on common interests and goals. The Circles of Support are designed to assist participants to achieve their selected short and long-term life goals. A Circle of Support process provides up to three allies per

participant or family. Currently, there are seven CPPC communities implementing the Circles of Support strategy.

The Neighborhood Partner Program is a community volunteer effort to support families and prevent child abuse, neglect, and domestic violence. The Neighborhood Partner program is a way to bring families, neighbors and professionals together. They to help identify family strengths, plan for overcoming hardships, and address roadblocks that may lead to added family stress. In the Cedar Rapids' Neighborhood Partner Program, 24 active volunteers logged 5,877 hours in a six month period of time.



COMMUNITY/NEIGHBORHOOD NETWORKS: LESSONS LEARNED

Community awareness, engagement and educational activities (levels 1 & 2) need to be part of a larger strategic plan with clearly defined outcomes. These activities need to be used as stepping-stones toward long-term goals that include the development of a network infrastructure for informal and formal supports (levels 3 & 4). Often, level 1 and 2 activities are implemented as individual projects that are short-term. In order to establish level 3 implementation, communities must build strong, long-term collaborations and partnerships that add sustaining resources beyond the CPPC allocation.

INDIVIDUALIZED COURSE OF ACTION /FAMILY TEAM DECISION-MAKING

An individualized course of action (ICA) is implemented for children and families who are identified by the community and/or DHS as being at substantial risk of child abuse and neglect. In Iowa, this approach is referred to as Family Team Decision-Making (FTDM) which includes the family team meeting planning process. If communities are to work together to reduce the incidence of child abuse and neglect, no single response can serve each and every family's needs. In Community Partnerships sites, a family team meeting is convened with families, neighbors, and local service providers. This meeting results in tailor-made plans designed to support the family and ensure the safety and well-being of the children in that family. These plans identify the specific activities to be carried out by parents, friends, extended families, and other formal and informal supports. Action plans build on the strengths of families - as opposed to focusing solely on their weaknesses - and adapt to cultural and racial norms that vary from family to family.

ICA/FTDM: LEVELS OF IMPLEMENTATION

In every Community Partnerships site, families have access to family team meetings (FTM). For many areas, this is a new approach and still in a developmental stage. These areas are in the process of developing tracking mechanisms, partnering with DHS and other community partners and implementing a satisfaction survey. Department of Human Services piloted a survey which was used statewide in 2006, and is in the process of revising the survey based on the pilot results. A number of sites have continued to implement this pilot survey, and others have developed their own surveys. Other sites are waiting for the DHS survey to be completed before they proceed.

The sites' evaluation report will be redesigned to capture the information needed to determine sites' level of participation. The current reporting format does not ask specific questions linked to the levels for this strategy. However, 67% of the CPPC sites were able to report the number of FTMs held. Department of Human Services-involved families participated in 3,815 FTMs, and 296 FTMs occurred for families not involved with DHS.

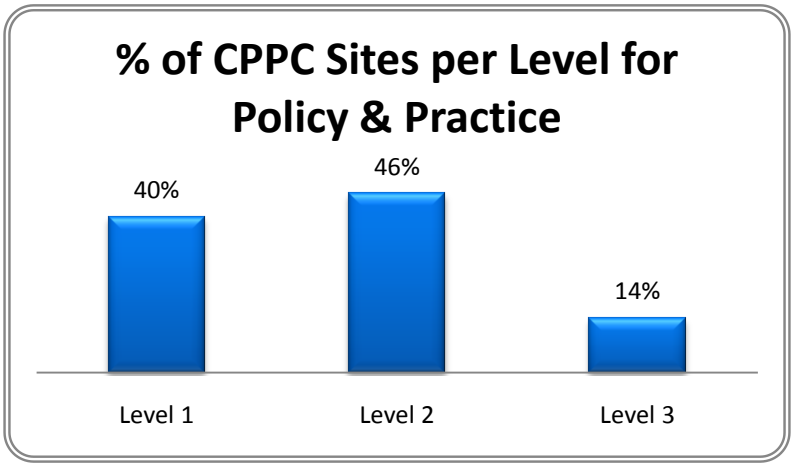
ICA/FTDM: LESSONS LEARNED

Some essential qualities for success of the ICA/FTDM strategy are constant attention to training, mentoring and management support. Development of practice skills is essential to enhance families' successes. When administrators and supervisors encourage and promote FTDM, the practice becomes common-place. Without such support, it is sporadic and inconsistently applied. The skill level of FTDM facilitators is one of the most important factors in team building and comprehensive planning. To ensure quality, a local infrastructure needs to be developed, which includes ongoing evaluations of practice and a feed-back loop process. These are essential to addressing practice concerns and making course corrections.

POLICY AND PRACTICE CHANGES

The Iowa Department of Human Services and child protection partners adopted several new policies, practices, roles and responsibilities as a result of the CPPC. Department of Human Services has begun to make changes in the way it responds to reports of maltreatment, while still fulfilling its legal mandate to protect children from abuse and neglect. This process means refocusing staff to use different skills for working with families. If the child's immediate safety needs are met, but the family is still in need of help, then DHS workers connect parents to the services and resources they may need by first conducting a thorough strength-based assessment. Department of Human Services staffs act as experts or safety consultants to other members of the Partnerships network – assisting teachers, pediatricians, family support workers and residents in determining what they can contribute to child safety in the community, and how to effectively intervene when a child is at risk of harm.

POLICY AND PRACTICE CHANGE: LEVELS OF IMPLEMENTATION



Level 1 of the Policy and Practice Change strategy focuses on identifying a needed policy and practice change. Level 1 CPPC sites are involved in an assessment process to identify an issue(s) in the community that needs to be addressed. These sites are using surveys, focus groups, and collaborative processes to assist in identifying and prioritizing needed changes. Level 2 includes level 1 tasks plus conducting research on the issue, developing a plan, and beginning to implement the plan to address the needed change. Level 3 includes level 1 and 2 tasks plus implementing policy/practice changes, and re-evaluating implementation activities to ensure that these activities are successfully addressing the issue. Below is a list of issues level 2 and 3 sites are addressing:

- Strengthening communication between the community and DHS.
- Building stronger collaborative relationships with domestic violence advocates, DHS staff and other community partners.
- Improving community cultural competency.
- Building community supports to prevent re-abuse.

- Improving informal supports.
- Addressing items identified through the Quality Service Reviews (QSR) and Child and Family Services Review (CFSR).
- Establishing a Parent Partners program.
- Focusing on the Transitioning Youth Initiative.
- Increasing substance abuse treatment services.
- Addressing transportation needs.
- Increasing visits for children in foster care with their parents.
- Integrating various community initiatives.
- Increasing community support to reduce out-of-home-placement.

POLICY AND PRACTICE CHANGE: LESSONS LEARNED

In order to facilitate success, sites need to start with a simple policy and/or practice change at the local level that is achievable. In order to build consensus and buy-in, it is important to recruit all partners that may be affected by the proposed change. Another important step toward policy and practice change is to gather research, data, and hands-on information pertinent to the proposed change. It is also essential to strategically develop training, provide technical assistance and disseminate information regarding the change.

COMMUNITY TRAINING

Throughout the years most sites have hosted trainings in their communities in order to strengthen the implementation of the four CPPC strategies. Participants generally represent DHS, domestic violence services, parents, community members, other service providers, schools, faith communities and others. The following is a list of trainings hosted by CPPC sites:

- DHS 101
- CPPC 101
- Building A Better Future (Parent Partners)
- Understanding domestic violence and substance abuse
- Understanding Poverty
- Cultural competency and understanding racism and disproportionality
- Transitioning Youth
- Circle of Support - Dream Path and Allies training
- Various cross-trainings involving community partners
- Building Trust-Based Relationships
- Family Team Meeting Facilitation Training

STATE-LEVEL SUPPORTS & IMPLEMENTATION

A state-level parallel process to support the four Community Partnerships strategies was established from the initiative's inception. A shared decision-making process was and continues to be promoted through an infrastructure of committees. The ICA and networking strategies have received state-level support through the development of technical assistance, training curriculum, train-the-trainer programs and other system supports. Over the last five years, there has been numerous state-level Policy and Practice Changes influenced by the Community Partnerships initiative. The following discussion presents a more detailed description of each of the strategies and state-level support for implementation.

SHARED DECISION-MAKING

During the early years, 1996-2000, when Cedar Rapids was beginning to implement Community Partnerships for Protecting Children (CPPC), the Edna McConnell Clark Foundation gave the State of Iowa additional funding to examine ways to expand the CPPC to other areas. In 1999, a steering committee, comprised of DHS Field Supervisors and staff from Central Office, was formed to discuss the ramification of CPPC expansion. This committee determined that it would take a concentrated effort and recommended that a fulltime staff person be hired to fully explore the initiative and the prospects of expansion. In March 2000, a fulltime CPPC coordinator was hired and began working with the committee.

In 2001, the State of Iowa was awarded an additional grant from Edna McConnell Clark Foundation to expand CPPC to five new pilot sites. During this time, representatives from the new pilot sites started to attend steering committee meetings. The membership of the steering committee shifted from being all DHS staff to broader community representation including providers, domestic violence advocates, FTM facilitators and others. As membership expanded, the focus of the steering committee shifted to support the five new CPPC sites' implementation and to identify state policy and practice issues.

In 2003, Iowa legislators supported CPPC with an allocation of funds and have continued to increase these funds every year. As a direct result, CPPC is now statewide and site allocations are supported by state and federal funds. As CPPC expanded, the governing structure and the shared decision-making process were reshaped to accommodate the growth.

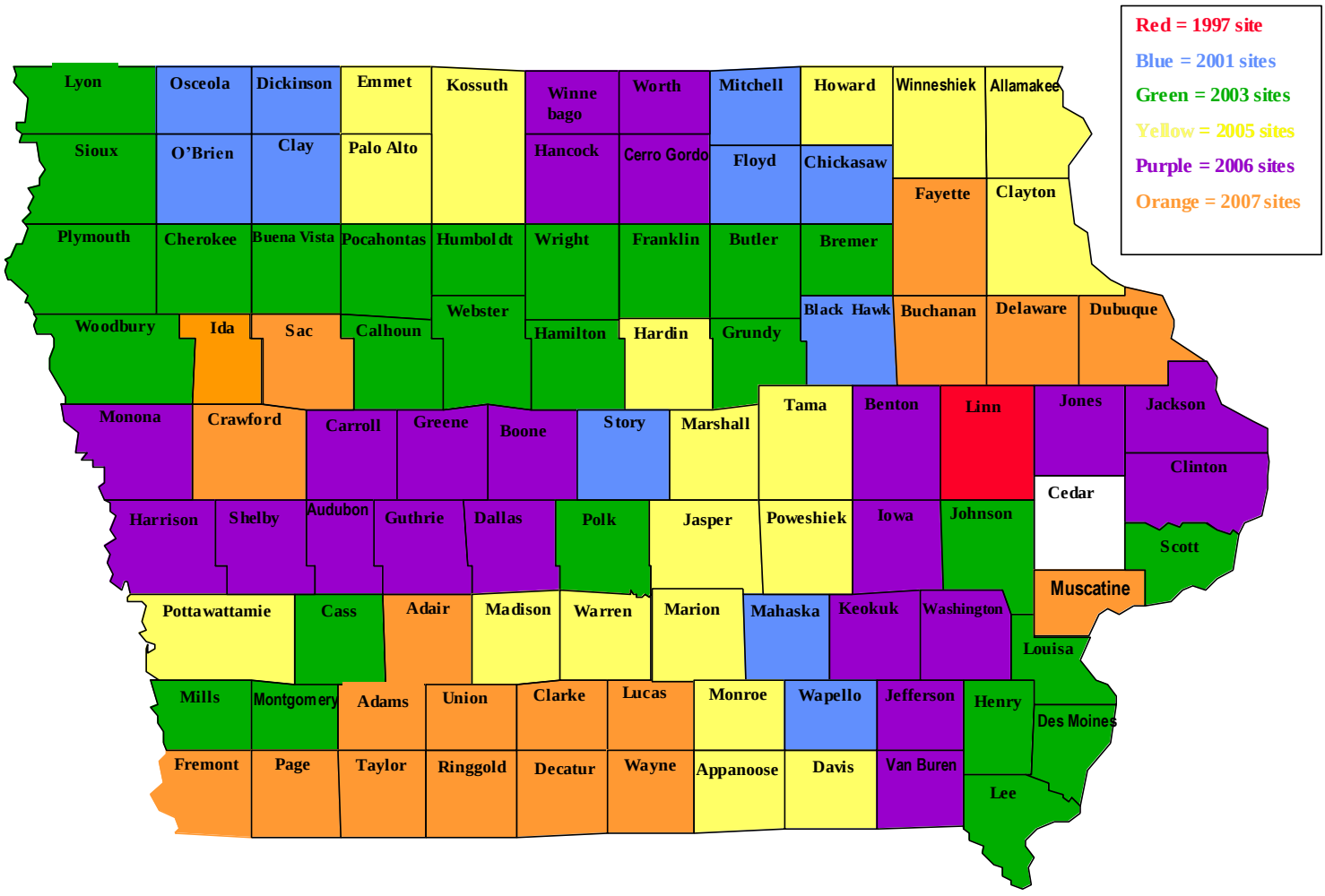
Today in Iowa, over thirty-nine CPPC local decision-making groups, involving ninety-eight counties, are guiding the implementation of CPPC. Representatives and site coordinators from these CPPC sites meet in three different regions four times per year and attend two statewide meetings. These meetings provide peer support and sharing, education, dissemination of information, relationship building and discussion of policy and practice

recommendations. The focus of these meetings is to provide needed support that enables CPPC sites to strengthen and expand local CPPC implementation.

In 2004, the Community Partnership Executive Committee was formed to develop statewide expansion and infrastructure supports that include technical assistance, training, policy and practice changes, and evaluations of CPPC implementation. The statewide Community Partnership Executive Committee (CPEC) provides policy and practice recommendations to DHS administration based on feedback from the Community Partnership Regional Committees. The CPEC is comprised of representatives from local communities, a DHS representative from each service area, representatives from statewide organizations and agencies, parents and youth.

To accommodate further expansion, the CPEC formed ten task teams that respond to recommendations developed through the community and regional shared decision-making process. Each task team addresses specific goals and/or activities needed to support the CPPC. These teams are: Community Education; Communication; Family Team Decision-Making; Legislative; Outcomes; Domestic Violence; Parent Partners; Transitioning Youth; AmeriCorps; and Community-Based Child Abuse Prevention. The task teams meet as needed to address various developmental issues for their respective categories. See the Appendix B for task team logic models.

Community Partnerships for Protecting Children



NEIGHBORHOOD/COMMUNITY NETWORKING

As CPPC rollout expanded beyond the original six sites, so did the need to develop consistency in how CPPC was explained to newcomers. "Community Partnership 101" was developed to address this need. This training provides a framework that sites can utilize to engage community and professional participants. The next training to be developed was "Community Connections" which addresses Neighborhood/Community Networking. Also, an orientation was offered to new sites starting to organize.

These trainings were combined and expanded into a two-day training called "Community Partnership Immersion". This training is most often utilized by new sites; however, existing sites with new leadership or new members also attend. Iowa's "Community Partnership Immersion" training has drawn Community Partnership stakeholders from other states to see this impressive process.

On-going communication, education and sharing are provided during the regional and statewide meetings as well as at the annual conference. Future trainings to be developed are focused on leadership and community organizing. Currently, Prevent Child Abuse Iowa coordinates these educational activities. Also, sites have access to the Community Partnership DVD, brochure, newsletter and website, which has information materials and tools for all aspect of Iowa's CPPC.

INDIVIDUALIZED COURSE OF ACTION/FAMILY TEAM DECISION-MAKING

In 2004, a work group was formed with representatives from the private and public sectors, urban and rural areas, and each service area to develop standards and facilitator criteria for family team meetings. This group examined the various models of team meetings (Family Unity, Family Team Conferencing and Wrap-around) and selected common themes to shape Iowa's standards for the family team meeting (FTM). At this time, criteria for being an FTM facilitator were established. Facilitators are required to attend 18 hours of classroom training, co-facilitate a minimum of two meetings with an experienced facilitator, and have a written evaluation of their work completed. Individuals who want to be approved facilitators need to submit verification of both the training and evaluation.

The established CPPC FTM written curriculum is comprised of two, two-day sessions held approximately one month apart. The first session is called "Building Trust-Based Relationships" and the second session is called "Family Team Facilitation". The Child Welfare Policy and Practice Group helped to provide the foundation of this curriculum. One of these trainers was Cornelius Bird who trained in Iowa for five years and coached and mentored many of Iowa's trainers. The Family Team Meeting task team established criteria for becoming an approved trainer and a master trainer. Currently, we have eight approved trainers and four master trainers. For more information regarding this criteria please see the CPPC website at www.dhs.state.ia.us/cppc.

Since 2005, Family Team Meeting Seminar teleconference calls have been held bi-monthly. Approximately 30-40 FTM facilitators participate in these educational calls. To address the

need for coaching and mentoring, the FTM Learning Center was developed with the Partnership for Safe Families in Cedar Rapids. (This is the name of Cedar Rapids's CPPC). Individuals can come to the Learning Center to fulfill the coaching and mentoring requirements to become an approved facilitator. Through the Learning Center, the Child Welfare Policy and Practice Group provided coaching and mentoring for 30 DHS supervisors. The FTM Learning Center also provides advanced FTM and coaching and mentoring training.

POLICY & PRACTICE CHANGES

In the Children and Family Service Program Improvement Plan, the Department of Human Services (DHS) has identified the family team meeting process as a primary practice change that is currently being implemented statewide. Through the family team meeting process, families and informal networks are more engaged and plans are individualized. Through the restructuring of the provider delivery system, (referred to as the Service Array Contracts), supports and services are design to meet the specific needs of families and are more flexible, family centered and strength-based. Prior to the restructuring, the number and types of services available to families were limited.

To strengthen collaboration with domestic violence programs, DHS contracts with the Iowa Coalition Against Domestic Violence (ICADV) to provide technical assistance (TA) and/or training to DHS staff and communities. Domestic Violence technical assistance and/or training is available for: case consultation; Impact of Domestic Violence (DV) on Child Welfare; DV and Family Team Meetings; DV & Cultural Competency; Cross-Training; Community Partnership and DV Strategic Planning; Focus Groups; and Batterers as Parents. ICADV staff is also available for telephone case consultation within 48 hours of request.

With the support of the Iowa Commission on Volunteer Service (ICVS), Prevent Child Abuse Iowa started a new AmeriCorps project in the fall of 2007. Under PCA Iowa's overall direction, this project has placed ten AmeriCorps Members at Community Partnerships for Protecting Children sites. Members assist Partnership sites in their efforts to reach out earlier to stressed families and to intervene more comprehensively when abuse occurs. AmeriCorps members assist sites by increasing community involvement efforts, strengthening community connections, and building neighborhood networks. Among their activities, AmeriCorps members:

1. Help Partnership sites organize a network of neighborhood and community supports for families. Members enhance awareness of the Partnership in meetings with and presentations to professionals and community groups; develop marketing materials and resources for public presentations and the internet; and assist in the development of family support programs.

2. Assist sites in better engaging families through the family team meeting process. Members help arrange family team meetings, provide advice and support for attendees, and arrange needed sources of community support for families.

3. Work to strengthen the shared decision-making teams that guide local Partnership efforts. Members support team development by identifying and recruiting new members, coordinating the work of the team, and assisting in its development of new family support.

The management of the Community Partnership approach is achieved through a partnership of public, private and non-profit entities. Throughout the last five years there has been an increase in funding to support building statewide CPPC capacity. These funds include state allocations, Promoting Safe and Stable Family federal funds and, most recently, Community-Based Child Abuse Prevention funds which were realigned to support CPPC implementation. PCAI was awarded a private foundation grant and AmeriCorps funding to strengthen the CPPC efforts. With the increase in resources, several new positions and resources have been established to bolster capacity. The following is a list of paid positions or contracted services supporting Iowa's CPPC implementation:

- One fulltime state CPPC coordinator position, who oversees all aspects of the Partnership, works directly with communities to tracks outcomes and evaluates progress.
- One fulltime Prevent Child Abuse Iowa (PCAI) associate-coordinator who coordinates the regional and statewide meetings, annual conference, Immersion Training, legislative activities and other community education activities.
- One fulltime PCAI AmeriCorps coordinator and ten AmeriCorps volunteers that assist CPPC sites.
- One fulltime PCAI Community-Based Child Abuse Prevention (CBCAP) contracted manager for statewide prevention programming connected to CPPC sites.
- One fulltime Iowa Coalition Against Domestic Violence contracted position who provides domestic violence technical assistance and training to DHS staff, providers and community partners.
- One fulltime Iowa State University staff contracted position who manages FTM training, FTM curriculum development, FTM train-the-trainers, coordinates Parent Partners Program and assists with administration.
- One fulltime Youth Policy Institute position funded by the Jim Casey Foundation, housed in DHS central office who coordinates the implementation of the Transitioning Youth Initiative, development of curriculum and implementation the Dream Team concept.
- Technical assistance with the development of the Parent Partner curriculum, train-the-trainer, protocol and other related Parent Partner activities.
- Technical assistance with the FTM seminar calls, FTM task team and other related FTM activities.
- Technical assistance from the FTM Learning Center for FTM coaching and mentoring and the development and implantation of advanced FTM training sessions.
- Contract with several FTM trainers and others for specific activities and trainings.

CONCLUSION

Throughout Iowa, communities have formed Partnerships focused on reducing child abuse through community organizing and awareness, strengthening linkages and accessibility to supports, and building a system of community networks and supporting strength-based, individualized approaches. These Partnerships continually address needed policy and practices changes that enhance families' ability to make needed changes and reduce barriers to success.

The Community Partnership approach has and continues to influence new approaches identified and implemented in the CFSR Program Improvement Plan and DHS's focus on preventing child abuse, reducing re-abuse, safely decreasing out-of-home placements, timely reunification, and other outcomes. It is the combination of all these efforts that have contributed to the improvement of Iowa's outcomes.

APPENDICES